Reference Number:	603-07-DD
Title of Document:	Do Not Resuscitate (DNR) Operational Guideline
Date of Issue:	August 4, 1992
Effective Date:	August 4, 1992
Last Review Date:	February 5, 2003
Date of Last Revision:	February 5, 2003 **(Revised)**
Applicability:	SCDDSN Regional Center Patients

Section 1 – Purpose

The South Carolina Department of Disabilities and Special Needs recognizes that while cardiopulmonary resuscitation (CPR) may prevent sudden, unexpected death, it may be appropriate for a responsible physician, in certain circumstances to issue an order not to attempt CPR of a patient. Decisions about CPR concern all human beings and are not unique to individuals with mental retardation.

This guideline complies with the Emergency Medical Services Do Not Resuscitate Order Act, S.C. Code Ann. Section 44-78-10 (Supp. 2001). It attempts to clarify and establish the rights and obligations of physicians, patients, their families, and the department regarding CPR and the issuance and obeyance of orders not to resuscitate. This guideline does not address unexpected, emergency cases of cardiopulmonary failure, where CPR administration is considered the preferred course of treatment. See Section 9, page 7, for definitions.

Section 2 - Guideline

Efforts should be made to resuscitate patients who suffer cardiac or respiratory arrest except when the physician determines in his/her own professional judgment that circumstances indicate that administration of CPR would be futile or not in accord with the desires or best interests of the patient.

Resuscitative efforts should be considered futile if they cannot be expected either to restore cardiac or respiratory function to the patient or to achieve the expressed goals of the patient capable of giving consent.

If a patient is unable to render a decision regarding the use of CPR, a decision may be made by a surrogate decision maker, based on the previously expressed preferences of the patient or, if such preferences are unknown, in accordance with the patient's best interests as determined by his/her surrogate with the advice of the family and physician. The process for surrogate decision-making is covered in the Department's Consent Directive, 535-07-DD.

Do-Not-Resuscitate (DNR) orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and should not influence other therapeutic interventions that may be appropriate for the patient, including nutrition, hydration, palliative care, pain relief, or other ongoing treatments.

Section 3 – Reasons for Considering a DNR Order

A) Cardiopulmonary resuscitation (CPR) is routinely performed on patients who suffer cardiac or respiratory arrest. Resuscitation is presumed to be the preferred course of treatment and specific consent is not required to provide CPR to a patient in distress. However, two exceptions to the presumption favoring CPR have been generally recognized:

   1) Situations where the patient or his surrogate have expressed a preference to withhold CPR, and;
   2) Situations where, in the judgment of the responsible physician, CPR would be futile or medically ineffective or only possibly temporarily prolong the dying process without discernable medical benefit to the patient.

B) Competent adult patients have the legal right to refuse medical interventions including CPR. Any patient, who understands the nature of his/her illness or medical condition and can make informed, reasoned choices about treatment, can refuse resuscitation for medical or non-medical reasons. For procedures concerning competency to make health care decisions, refer to the Department's Consent Directive, 535-07-DD.

C) A DNR order therefore, may be appropriate when:

   1. A competent patient has made an informed, reasoned choice to forego CPR;
   2. The responsible physician has determined that the patient is terminally ill;
   3. The patient is in a persistent vegetative state;
   4. The patient has a progressive degenerative condition;
   5. The responsible physician determines that CPR would be futile; or
   6. That CPR would cause more harm than possible benefit.

Section 4 – General Procedure for DNR Order

A) Determining the patient's capability to consent, holding discussions with the patient, next-of-kin or surrogate and helping them to decide may require time that is not available in an emergency. Therefore, a Do-Not-Resuscitate (DNR) decision should be made under conditions that permit consultation and reasoned decision-making. **Resuscitation should be presumed as the preferred course if no prior decision has been made to forego resuscitation, unless futile in the physician's professional judgment.**

B) The Do-Not-Resuscitate (DNR) Order is the responsibility of the responsible physician. Only Departmental physicians attending the patient or consulting physicians may write a Do-Not-Resuscitate (DNR) Order for consumers residing in DDSN facilities.

C) All Physician Do-Not-Resuscitate (DNR) Orders are written. The physician may not give verbal DNR orders. The order must be written in full, dated, and signed. It will expire after thirty (30) days and may be reordered as appropriate. The order must be documented and explained in the patient's progress notes. The medical progress notes will also indicate the patient's ability to consent and, if capable of consenting, his/her concurrence (written where possible). In the case of a patient incapable of consenting, the progress notes should indicate the discussion with and written concurrence of the surrogate. The written concurrence of the surrogate must include the date, time, and signature of surrogate and name of physician with whom the patient's condition was discussed. It must be filed in the patient's progress notes. Any review or consultation by the ethics committee will also be documented in the progress notes. South Carolina Emergency Services DNR form is also filled in and filed in chart. The responsible physician will review DNR order and seek renewed consent at time of annual Single Plan meeting or sooner if needed. All DNR's will be reviewed by the local ethics committee for consistency with the procedural requirements of this directive (603-07-DD).

D) Physicians will promptly inform others who are responsible for the patient's care, particularly the nursing staff, about the decision not to resuscitate. All who are responsible for the patient's care should understand the order and its implications.

E) If a patient is admitted or transferred from another facility within the Department of Disabilities and Special Needs with a Do-Not-Resuscitate (DNR) Order, the receiving physician will confer with the patient, if able to give consent, or the surrogate of a patient unable to give consent, and determine whether they concur with the continuation of the Do-Not-Resuscitate (DNR) Order. If the patient or surrogate desires continuation of the DNR order, a new order will be initiated if the receiving physician agrees. If this physician disagrees with the decision, then refer to the procedure for transfer in 7-A.

F) A Do-Not-Resuscitate Order (DNR) should not affect other treatment decisions. Specific attention should be paid to making respectful, responsive, competent care available for patients who choose to forego life-sustaining procedures. Therefore, orders for supportive and palliative care should be written separately. All efforts to provide comfort and relief from pain will be provided.

G) Review of Do-Not-Resuscitate (DNR) Orders will be accomplished by the responsible physician when there is a significant change in the patient's condition and/or diagnosis. In all cases, the orders must be renewed every thirty (30) days.

Section 5 - Resuscitation Decisions for Competent Patients

A) The voluntary choice of an informed patient able to give consent will determine whether cardiopulmonary resuscitation will be undertaken. A patient able to give consent may request a Do-Not-Resuscitate (DNR) Order at any time. This decision should be reached consensually by the responsible physician and the patient. Care should be taken to assure an accurate understanding of such decisions by the patient. The physician should note in the medical records the mental condition of the patient in reference to the decision which led to an informed decision along with the Do-Not-Resuscitate (DNR) Order.

B) When the responsible physician finds the patient's preference to be morally unacceptable and is unwilling to participate in carrying out the choice, he/she should transfer responsibility for the patient to another physician.

C) A patient able to give consent who requests or agrees to entry of a Do-Not-Resuscitate (DNR) Order always has the right to have such order withdrawn upon request. If the patient later becomes unable to give consent, his/her decision made while capable of giving consent shall be respected. For a patient capable of giving consent, the consent of the next-of-kin or a surrogate is not required. Family disagreement with the decision of the patient is not a basis to override the patient's choice and cause cancellation of the Do-Not-Resuscitate (DNR) Order.

   However, the family may be informed of such decisions, unless the patient specifically requests that they not be so informed, in which case the facility director or his designee should inform the family of the patient's wishes and the option they have of pursuing judicial relief.

D) In the cases of children less than 18 years of age who are capable of giving consent, their preferences will be respected if they choose to be resuscitated regardless of their parents' or family's wishes. When a minor chooses not to be resuscitated, the wishes of his/her parents will be respected. Refer to the Department's Consent Directive, 535-07-DD.

Section 6 - Resuscitation Decisions for Incompetent Patients

A) The voluntary choice of a surrogate decision-maker of a patient incapable of giving consent will determine whether
cardiopulmonary resuscitation will be undertaken. The patient should be involved, however, in the discussions about care and treatment to the extent of his/her capabilities allow.

B) While capable of giving consent, the patient may have anticipated the possibility of later incapability and may have given explicit verbal or written instructions or expressed his/her desires concerning a DNR order. In such situations, the surrogate decision should reflect that decision. Refer to the Department's Consent Directive, 537-07-DD.

C) In the absence of prior explicit instructions from the patient, the family or surrogate may express their feelings concerning the Do-Not-Resuscitate (DNR) decision. The family or surrogate of the patient must be counseled by the responsible physician on the ramifications of a Do-Not-Resuscitate (DNR) Order. If the family and physician agree, a Do-Not-Resuscitate (DNR) Order will be entered in the patient's medical record. When there is internal family conflict within the same level of decision-making authority concerning the Do-Not-Resuscitate (DNR) Order, the order will not be written until the conflict has been resolved. Until resolution of the conflict, resuscitation should be presumed as the preferred course, unless the responsible physician finds the administration of CPR to be futile as defined in this policy directive.

D) The surrogate may revoke a previous request for a Do-Not-Resuscitate (DNR) Order by contacting the responsible physician.

E) A patient unable to give consent may have no family or surrogate available, willing, or able to be involved in making decisions on behalf of the patient and the responsible physician believes that a Do-Not-Resuscitate (DNR) Order is proper. When there are no relatives or surrogate with whom the responsible physician can consult regarding resuscitation of the incompetent patient, the responsible physician must consult with another staff physician. If the second physician's opinion differs from that of the responsible physician, resuscitation should be presumed as the preferred course until the situation can be reviewed by the Ethics Committee. Refer to the Department's Consent Directive, 535-07-DD for the process of obtaining consent in such situations.

Section 7 - <u>Conflict Resolutions</u>

A) Should an apparently unresolvable difference of opinion develop on the part of the responsible physician, nursing staff, other health care providers, the patient, surrogate or the patient's family develop, the responsible physician should either:

1) Withdraw or be reassigned from the case.
2) Seek resolution through the Regional Ethics Committee.

B) The actions of the Ethics Committee and its members in helping resolve dilemmas which may arise should be considered advisory in nature and not intended to interpose a third party between the responsible physician and patient or the responsible physician and surrogate or family members. The outcome of consultations by the Ethics Committee is to assist in clarifying available options and improving communication.

Section 8 - <u>Medically Ineffective Resuscitations</u>

Responsible physicians are not obligated to initiate or continue medically ineffective treatments or futile treatments. When death is imminent for a patient, any treatment including resuscitation that cannot reasonably be expected to be effective can be omitted. Medically useless treatment

does not include treatment that is provided for the patient's comfort, care, or alleviation of pain and does not include feeding and hydration.

Section 9 – Definitions

1. Resuscitation - Use of any or all of the following in order to maintain life in the event of cardiac or respiratory failure: tracheal intubation, manual or mechanical assisted ventilation, externally administered cardiac massage, electrical defibrillation and full use of emergency drugs.

2. Do-Not-Resuscitate (DNR) Order - A written order by the responsible physician to suspend the otherwise automatic initiation of cardiopulmonary resuscitation. The Do-Not-Resuscitate (DNR) Order does not preclude**:** maintaining an adequate airway by suctioning the mouth, nose, pharynx and trachea or the Heimlich maneuver, and other indicated medical and surgical therapy including but not limited to antibiotics, nasogastric or other type of tube feedings, parenteral hydration and feeding, blood products, and cardio-active substances.

3. Palliative Care – Medical care designed to provide comfort and to alleviate pain and suffering to the fullest extent possible. This care is usually provided to a patient during the last stages of life when no active treatment is being provided. Department prevailing policy is that hydration and nutrition will not be withdrawn unless there is clinical indication.

4. Terminal Condition - A "terminal condition" means an incurable or irreversible condition that within reasonable medical judgment will cause death within a reasonably short period of time. It is the final stage of a medical condition which would normally result in death and in which resuscitative measures would be effective or would only postpone death for a brief period of time and would not be in the patient's best interest.

5. Cardiopulmonary resuscitation - Refers to any means used to restore ventilation and/or circulatory function until both are restored or until the patient is pronounced dead.

6. Responsible physician - The attending physician or primary care physician.

7. Patient capable of consenting to DNR - An adult who has the ability to communicate and understand information and has the ability to reason and deliberate about the choices involved. As mentioned above, refer to the Department's Consent Directive, 535-07-DD.

8. Patient incapable of consenting to DNR - An adult who is unable to appreciate the nature and implications of his/her condition, or to make reasoned decisions concerning his/her care or to communicate decisions concerning his/her care in an unambiguous manner. This status should be verified by clinical assessment of the patient's mental and emotional status by two physicians.

9. Surrogate – A person representing the patient where that patient is incapable of giving consent. Person as defined in Department Consent Directive 537-07-DD.

10. Ethics Committee - The Department has ethics committees at each regional center. Any issues or disputes concerning DNR should be presented to the ethics committee for its recommendation. Final DNR decisions remain with the responsible physician.

11. Persistent Vegetative State – A state of unconsciousness that involves no behavioral evidence of self-awareness or awareness of surroundings in a learned manner indicating any neocortical activity. There is only primitive reflex activity of muscles and nerves showing low-level conditioned reflexes at the brainstem level. It is an irreversible, permanent state of unconsciousness from which to a reasonable degree of medical probability there can be no recovery. A ninety (90) day wait is required before this diagnosis can be made, unless there is clear medical evidence of massive destructions or atrophy of the brain.

12. Progressive Degenerative Condition – A medical condition diagnosed by the responsible physician where the patient's health is degenerating so rapidly and with such momentum that the application of extraordinary care would be medically ineffective and futile. The rapid decline in health is irreversible and will most likely lead to death.

13. Futile Care – Treatment including CPR is futile if it offers no benefit to the patient because appropriate therapy has failed and physiological improvement is not reasonably expected. The responsible physician may determine treatment to be of no benefit to the patient because the natural course of the patient's medical condition would result in death within a foreseeable, short period of time and the application of resuscitative measures, even if successful, would only temporarily postpone death and would not be in the patient's best interest.

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